AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS AND INFORMATION FOR SELF

TO WHOM IT MAY CONCERN:

I, _____, social security number (SSN)
(Print full name of person GIVING release)

_____, hereby authorize
(SSN of person GIVING release)

_____ who is my ☐ spouse ☐ ex-spouse
(Name of person who is GETTING permission)

☐ other _____to have access to any and all information regarding

my ☐ medical ☐ psychiatric ☐ counseling ☐ other _____ records.

I also authorize the person indicated above to speak to any personnel who may have information regarding such records, and to receive copies of documents relating to these accounts.

This authorization expires ☐ 1 month ☐ 3 months ☐ other _____ from the date of signing below. Copies of this authorization shall be regarded as effective as the original.

_____
(Signature of person GIVING release)

SUBSCRIBED AND SWORN to before me this ____ day of _____, 20_____

at _____, Alaska.

_____
Notary Public in and for _____
My Commission expires:_____